AZ Medicaid Technical Consortium Meeting

June 13, 2006
11:00 AM to 12:00 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Attendees:

(Based on sign-in sheets)

Abrazo Health	**APIPA**	**Phoenix Health Plan**
JoAnn Ward	*Chaim Talmon*	*Jim Ten Eyck (teleconference)*
ADHS	*Sharon Zamora*	
Brian Heise	**Bridgeway**	*Marcia LeBlanc (teleconference)*
Jeanette Heller	*Lori Destifanes*	*Allan Tiana (teleconference)*
Ben Curiel	**Capstone**	**Pima Health System**
Dimiter Pekin	*Lydia Ruiz*	*Mark Hart (teleconference)*
Paula Rendfeld	**Care 1st**	*Mary Kaehler (teleconference)*
AHCCCS	*Anna Castaneda*	**Pinal LTC**
Peggy Brown	*Marlene Peek (teleconference)*	*Cheryl Davis*
Deborah Burrell	**Cochise Health Systems**	*Jennifer Schwarz*
Barbara Butler	*Marcia Goerdt (teleconference)*	**SCAN Health Plan**
Christi Coppedge	*Susan Speicher (teleconference)*	*Earlene Boyd (teleconference)*
Ester Hunt	*Evelyn Valdez (teleconference*	**UHC**
Dora Lambert	**DES**	*Sean Stepp (teleconference)*
Dan Lippert	*David Gardner*	*Ramana Tunuguntla*
Jacqueline McElroy	**Evercare Select**	**UPH**
John Murray	*Michele Linderot*	*Eric Nichols*
Lori Petre	*Lloyd Wright*	**Yavapai**
Brent Ratterree	**MCP & Schaller**	*Becky Ducharme (teleconference)*
Kermit Rose	*Joseph Pinelli*	*Jean Willis (teleconference)*

Welcome (Denny Bierl)

Thank you for coming. We're here to discuss the National Provider Identifier (NPI) project implementation within AHCCCS and to answer any questions you may have.

Mary Kay McDaniel just returned from the X12 conference, and will give a brief update.

Overview of NPI activity and Standards Body activity (Mary Kay McDaniel)

The Validator bids for AHCCCS are due back today. We anticipate a 30-45 day implementation start. If your transactions are not completely valid, you will want to begin using a validator of your own, for instance, Claredi, to identify the errors before submitting them to AHCCCS. We will be adding business rules such as the 1000 loop must match with the 2320 loop, and the files must balance. They will be rejected these files from the front end.

UB04 has been approved. It will be mandated 3/1/07 for Health Plans Clearing House and Information Support Vendors must use and accept UB04. Providers can use either form from 3/1/07 through 5/22/07, but as of 5/23/07 must use only UB04. WWW.NUBC.org has information concerning this, plus where you can order the forms.

CMS has announced that they will not be ready to accept the new 1500 Claim form on 10/1/06, and must push the go-live date back to 1/1/07. The dates industry wide are still 10/1/06 Health Plans, Clearing Houses and Information Support Vendors should be prepared to accept the new 1500 Claim Form. 10/1/2006 – 2/1/07, either form can be accepted, after 2/1/07, only the new form can be accepted. However, on 6/1/06 OMB renewed the old 1500 Claim Form version.

The NPI enumeration statistics as of 5/31/06, Arizona has 11,377 individual provider NPI, and 1,728 organizational NPI. There are almost 600,000 NPI at this time.

A question was raised as to why a provider or group should get their NPI now when it is not required until 2007. CMS responded that it will enable Medicare to build and validate their crosswalk in a timely manner, and assure timely payments at the deadline. Please note, the NPI rule does not prohibit Health Plans from requiring providers and suppliers to submit the NPI prior to the 5/23/07.

CMS has updated their FAQ list. Most notably, # 5815, after compliance, can an additional identifier be used? No. #5816 answers how you implement the NPI. The entire list will be forwarded electronically after this meeting.

The Insurance Business Process Application Error Code List Maintenance Committee (IBPAECLM) is researching new codes for the 824 form. There are 28 new codes expected to be approved for Claims attachments. There are six claim attachments pilots going on now, in addition to the one at Empire. CMS is pleased with the results so far. The providers involved like the attachments.

At Claim Adjustment Reason Code meeting, new code 196 "Claims Service denied based upon Prior Payer coverage," was approved. As of 4/1/07, four claim adjustment reason codes sent on 835, will require at least one remark code and have added phrase "When this code is used, at least one remittance advice remark code must be provided as supplemental clarification." These codes are #16 "Claim Service lacks information needed for adjudication," #17 "Payment adjusted because requested information not provided/insufficient/incomplete," #96 "Non-covered charges," #125 "Payment adjusted due to submission/billing error."

CMS will be adding new Claims Status codes for HSA. The modification rule is still in development to clarify Retail Pharmacy and DME, plus add certain definitions, especially the direct data entry. We expect the interim final rule out for E-Prescription soon. Data dissemination policy is scheduled for August publishing date.

NPI and 835 change request is out for Medicare, including changes to processing manuals. Please note, the current 835 has one NPI at the beginning. You will no longer be able to roll up all the providers under

one tax ID without a group NPI at the beginning. WEDI/NPI group will be discussing this. CMS will end the 835 contingency period. CMS has provided a software program through the MREC (Medicare Remit Easy Print) for providers without electronic 835 functionality. Some commercial payers are rejecting the MREC electronic form as it doesn't have the medicare logo. According to the HIPAA rule, it is illegal to require a provider to submit a paper claim if they can submit them electronically.

Four guides were approved for publication, the 5010 276/277, 5010 834, 5010 820, 4050 274 (not a HIPAA mandated transaction), as well as a provider directory and provider request response. The 837 5010s will be available for purchase this month. The 5010 270/271 had an informational forum with feedback to the public review. The draft for the 270/271 contains 3 new required search options, Member ID and DOB, Member ID, First Name, Last Name, and the final one Last Name, First Name, DOB. The committee agreed to make the final an optional search option.

New external codeset has been approved for the 837 transaction. It will be maintained by PHDFC, part of the Agency for Healthcare Research/Cost and Utilization Project. It will be a Payer topology. In the 837 transaction it discusses payer. Hospitals requested more of a Payer Topology, breaking down such things as Medicare HMO, Medicare PPO, Medicare POF, Medicare FFS or Medicare Drug Benefit. Medicaid will break down to Medicaid HMO, PPO, Primary Case Management or Medicaid Other. Payers are encouraging their providers to submit this information correctly. You can review this at PHDFC@cdc.gov.

Remark Codes and Claim Adjustment Codes reasons are updated after the X12 meeting. On August 1, 2006, the new remark codes will be posted for requests from March – June, 12/1 includes requests from July through October, and April 1 will include requests from November through February.

The 835 Coalition is working towards standardization on Claim Adjustment Group Codes, Claim Adjustment Reason Codes together with the amount. The way the 835 is laid out today, you cannot get a Claim Adjustment Reason Code and a Remark Code in a 1::1 relationship. There is some discussion of creating a new segment specifically for that, similar to the CAS segment. A new repeating element is being introduced in order to supply the remark code or Claim Adjustment Reason Code to inform providers every reason the claim was denied.

AHCCCS Project Update (Denny Bierl)

Concerning scheduling, you may have noticed changes when researching providers, as we did go into production with Provider and Reference subsystems. Should you notice any defects concerning those changes, please let us know. The next big phase is Claims and Encounters, Finance, 835, EDI and translator changes in support of NPI. These are scheduled to go into test on 6/22/06. If you are using the test region to test files, please be aware that the code in ATR will look very different after 6/22.

We have received around 800 NPIs to date and loaded into our database. According to the update by Mary Kay, there are some 13, 000 for the state of Arizona. Please remind your providers to notify you and AHCCCS of their authorized NPI numbers. That way, once the code is implemented, AHCCCS can continue to process the claims and encounters without pending due to no NPI on file.

A question related to out of state providers continuing to register with AHCCCS. Yes. The AHCCCS correspondence has all been changed to reflect both the AHCCCS provider ID and the NPI and will continue that way until further notice. The fact that providers receive an NPI doesn't change the requirement to register with the Medicaid agency, to go through credentialing, or any of the other processes that are already in place.

As far as address tracking and maintenance, there will be no changes. Currently, we keep in the AHCCCS system correspondence addresses, and as many service addresses as the provider informs us. You will not report the location code to us, but as providers notify us of office relocations or changes, the databases will be updated.

A question was submitted as to whether we will be validating the NPIs within AHCCCS using check digit methodology. Yes, that was promoted in the month of May. So far, only 1% of those submitted to us were sent incorrectly.

Finally, relating to edits, we will not be editing for referring provider IDs against our database. However, we will run the check-digit validation against the referring provider, and pend the encounter if it is not found. If an encounter is submitted from a Kentucky provider does not need to be a registered AHCCCS provider, but they do need to have valid NPIs.

HP – Will there be new editing requirements.
Brent Ratterree – if you are sending a provider ID, make sure the NPI number is valid. There are no changes in the registration requirements. If the provider is a prescribing or referring physician, they will require a NPI.

HP – On your provider crosswalk, are you planning on adding a static field for a tax ID?
John Murray – The tax ID is currently stored in the Provider Pay-to record using the location code in the Pay-to address. These records are in the biweekly extract sent to the Health Plans.

HP – Is AHCCCS expecting regarding recipients who attend services at one office in the morning, and a different office in the afternoon.
Denny Bierl – This appears to be limited to the DHS system according to our recent research. We'd like some examples so we can track them and see how they are being handled today.

HP – Is AHCCCS looking at accepting crossover claims from Medicare electronically and disbursing to plans or program contractors?
Mary Kay McDaniel – Health plans will need to connect with GHI and test with them separately, but we are in discussions with them to be able to do so when we go live. CMS has approved splitting out the claims and sending them to the separate plans, but GHI is behind with their connectivity. It will be a while before it happens.
Denny Bierl – This will be a future initiative.

Health Plan Project Plans and process (Lori Petre)
We have received all the initial project plans, and an email will be going out concerning current status. There are internal meetings regarding testing parameters. As soon as we have ironed that out, we will send it to you. Along with that, we will be looking for a Beta Tester Health Plan to test with us concerning that.

Provider Affiliation Process (John Murray)
We will be adding the NPI to the quarterly Provider Affiliation. We are improving this process, looking to send you the file through FTP instead of hard copy. We will also be sending confirmation emails to you regarding your successful file loads. This will be changed in the next 90 days.